DELIVERING the NEW CHILD DEATH REVIEW PROCESS ACROSS BEXLEY, LEWISHAM AND GREENWICH

Underpinning principles that shape the changes:

“To improve the experience of bereaved families, as well as professionals, after the death of a child

To ensure that information from the child death review process is systematically captured to enable local learning and, through the National Child Mortality Database, to identify learning at the national level, and inform changes in policy and practice”

Child Death Review Statutory and Operation Guidance (England), October 2018

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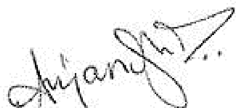
Child Death Review Process Partners

Commitment of Partners Across Three London Boroughs to Deliver Child Death Review Arrangements



Anjan Ghosh
Director of Public Health

Catherine Mbema
Interim Director of Public Health

Steve Whiteman
Director of Public Health

Andrew Bland
CCG Chief Officer

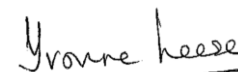
South East London
Commissioning Alliance
Partnership of Clinical Commissioning Groups

Michael Boyce
Deputy Managing Director and Director of Quality

Bexley
Clinical Commissioning Group

Martin Wilkinson
Managing Director

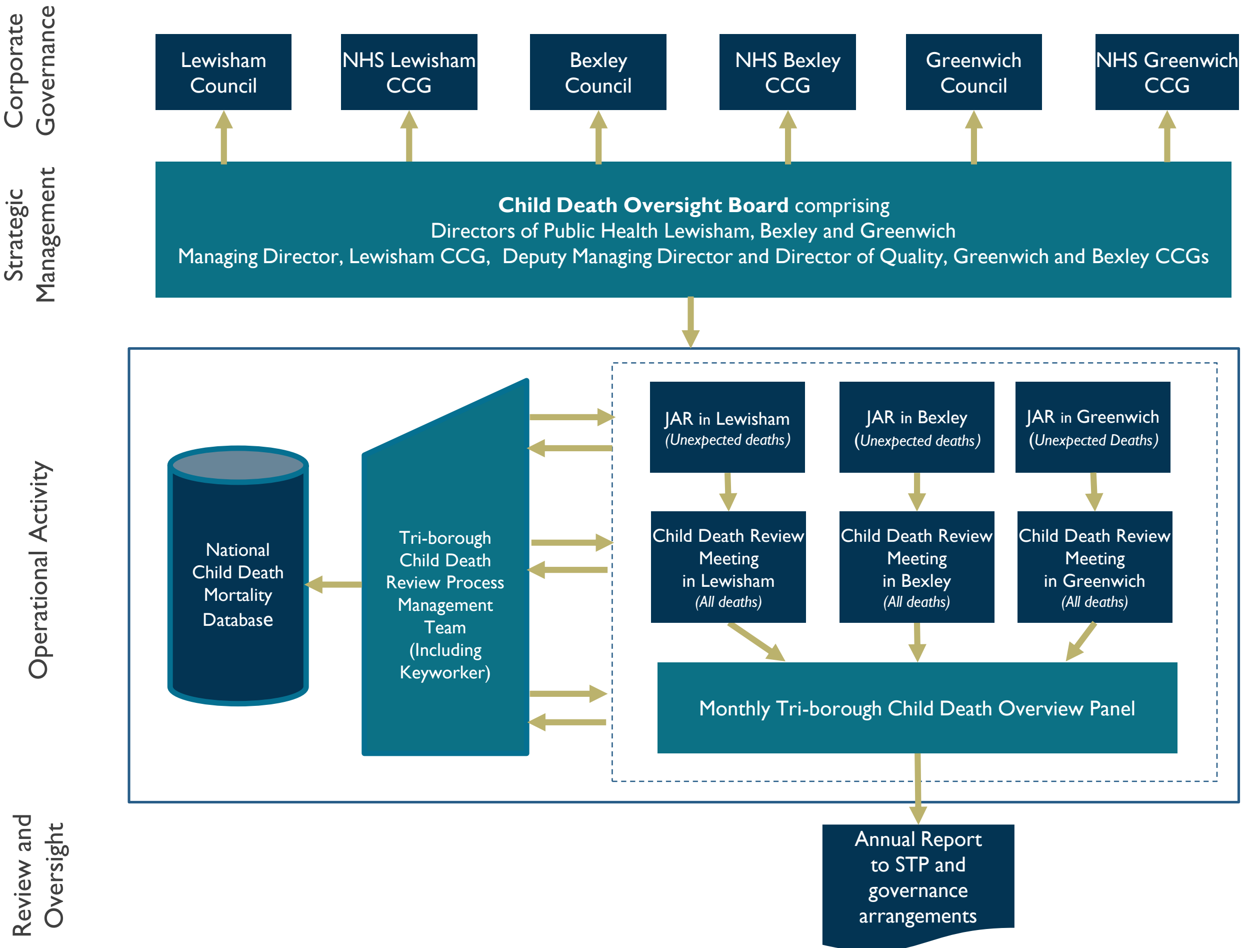
Lewisham
Clinical Commissioning Group



Yvonne Leese
Deputy Managing Director and Director of Quality

Greenwich
Clinical Commissioning Group

Governance of New Arrangements



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Child Death Review Process Arrangements

Partners and Funding

Bexley, Lewisham and Greenwich have agreed to combine and be treated as a single area for the purposes of Child Death Reviews. The Child Death Review Partners shown on the previous page have committed to contribute shared and equitable funding to support a single central ‘team’ to support all aspects of the management and administration of the Child Death Review Process from notification of the child’s death and assignment of a of keyworker through to review at the monthly Child Death Overview Panel (CDOP) including future costs of eCDOP.

Administration and Management

The Child Death Review Process central team will consist of a

- 1.0 Full Time Equivalent Child Death Review Process (CDRP) Manager
- 0.5 Full Time Equivalent Child Death Review Process (CDRP) Keyworker
- 1.0 Full Time Equivalent Child Death Review Process (CDRP) Administrator

Lewisham will act as the host for all posts within the Child Death Review Process central team.

Keyworker Role

Bereavement midwives and hospice workers, who currently undertake many aspects of the keyworker role for neonatal deaths and children who die in hospice (approximately 60% of child deaths) will continue to undertake this function.

A dedicated part time key worker will be based in the central team and will act as keyworker for all families that do not have a bereavement midwife or a hospice worker. Absence cover will be provided by the CDRP Manager to ensure that all families receive timely and consistent support.

When a child dies and an NHS Serious Incident Investigation is instigated, a 'case manager' will be appointed who will support the keyworker.

Joint Agency Response (JAR)

All deceased children who meet the criteria for a JAR will be transferred to the nearest Emergency Department. JARs will be the responsibility of the Designated Pediatrician, who will chair, and the CDRP Manager. Together with the CDRP Administrator they will liaise with the police, children's social care and other agencies. The acute trust or area where the child dies will be responsible for providing timely and detailed information and representation of all appropriate people to the JAR.

Child Death Review Meetings (CDRM)

The child's consultant at the acute trust or hospice where a child dies has responsibility for organising the CDRMs in their respective organisations. Where a child has died at home, this will be agreed on an individual basis. A protocol for CDRMs for Bexley, Lewisham and Greenwich children who die outside of the tri-borough has been developed. All those cases will be reviewed by the tri-borough CDOP regardless of where they occur.

Child Death Overview Panel (CDOP)

There will be a single monthly themed CDOP for the tri-borough where approximately five to eight cases will be discussed. Three chairs will each chair four meetings a year in rotation and agree holiday and absence cover among themselves. Scheduling of cases to be reviewed and all organisation and administration will be undertaken by the Child Death Review Process central team.

Use of eCDOP

The eCDOP system is used in the tri-borough and across London to ensure that information can be shared securely and that the National Child Mortality Database receives the required information for each child death. Joint funding has been agreed to continue use of the system from April 2020.

Annual Report

The three Chairs of CDOP will be responsible for producing an annual report on local patterns and trends in child deaths, lessons learned and actions taken as well as the effectiveness of the wider child death review process.

This report will be taken to the Tri-borough Oversight Group, which includes representatives from the local authorities, CCGs and police in the tri-borough. In addition, it will be taken to the appropriate governance committee within the South East London STP.

The Annual Report will be published on the three local authority and three Clinical Commissioning Group websites.